In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 99-510V
May 30, 2007
Not to be Published

BARBARA DAVIS,	*	
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Petitioner,	*	
	*	Entitlement; hepatitis B
v.	*	vaccine; 14 months later,
	*	complaints of symptoms
SECRETARY OF THE DEPARTMENT OF	*	after vaccination; no demyelinating
HEALTH AND HUMAN SERVICES,	*	disease; no expert medical report
	*	
Respondent.	*	

Clifford J. Shoemaker, Vienna, VA, for petitioner.
Linda S. Renzi, Washington, DC, for respondent.

MILLMAN, Special Master

DECISION[1]

Petitioner filed a petition on July 26, 1999, under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., alleging that she received hepatitis B vaccine on August 27, 1996, October 7, 1996, and February 25, 1997 and experienced an adverse reaction.

[1] Vaccine Rule 18(b) states that all decisions of the special masters will be made available to the public unless they contain trade secrets or commercial or financial information that is privileged and confidential, or medical or similar information whose disclosure would clearly be an unwarranted invasion of privacy. When such a decision or designated substantive order is filed, petitioner has 14 days to identify and move to delete such information prior to the document's disclosure. If the special master, upon review, agrees that the identified material fits within the banned categories listed above, the special master shall delete such material from public access.

On December 13, 2006, the undersigned issued an Order to Show Cause why this case should not be dismissed by February 16, 2007 because petitioner's neurological examinations overwhelmingly were normal.

On February 16, 2007, petitioner moved for an extension of time until March 16, 2007 to file an expert report and the records of Dr. Hurwitz and Dr. Wardell.

On February 21, 2007, the undersigned granted petitioner's motion for an extension of time to file the records and report until March 16, 2007..

On March 19, 2007, petitioner made an oral motion for a 30-day extension of time until April 18, 2007 to file an expert report and the records of Dr. Hurwitz and Dr. Wardell.

On March 19, 2007, the undersigned granted petitioner's motion for an extension of time.

On April 18, 2007, petitioner filed a motion for another 30-day extension of time until May 18, 2007 to file an expert report and the records of Dr. Hurwitz and Dr. Wardell.

On April 19, 2007, the undersigned granted petitioner's motion for an extension of time.

On May 18, 2007, petitioner filed a Status Report stating, "Counsel has spoken to Petitioner and she has decided to no longer pursue her claim." Petitioner's counsel was waiting for petitioner to send him a signed statement giving him permission to file a motion for judgment on the record. The undersigned does not need petitioner's permission to dismiss this case. It is an eight-year-old case without a single expert medical report in support of petitioner's allegations. The Vaccine Act, 42 U.S.C. §300aa-13(a)(1) does not permit the undersigned to rule on behalf of petitioner based solely on her own claims unsubstantiated by medical records or by medical opinion.

FACTS

Petitioner was born on October 23, 1962.

On July 19, 1994, petitioner saw her doctor with severe cramping since July 2, 1994 and also nausea. Med. recs. at Ex. 12, p. 12.

On July 20, 1994, after petitioner complained of a marked increase in pain and rectal bleeding, she was sent to Dr. Richard Wray's office. He was convinced that none of her pain was of rectal origin and thought the blood was coming from her vagina. Petitioner was directed to the ER and Dr. William Rawls, Jr., at Carteret Hospital. Med. recs. at Ex. 12, p. 11.

On July 23, 1994, petitioner saw Dr. William Rawls, Jr., a surgeon, at Carteret Hospital for a laparoscopy and dilation and curettage because of pelvic pain and abnormal period. She had minimal endometriosis and abdominal adhesions. Med. recs. at Ex. 12, p. 3.

On July 28, 1994, Dr. Rawls wrote that petitioner had a longstanding history of severe dysmenorrhea and pelvic pains, abnormal periods, a history of endometriosis, and a history of pelvic adhesions. Med. recs. at Ex. 12, p. 5. Petitioner had a total vaginal hysterectomy and bilateral salpingo-oophorectomy. *Id.*

On August 2, 1994, petitioner complained of a lump inside her throat. She felt pain down her neck and around her right breast. It was hard to swallow or eat. On examination, she did not have any masses or swelling. Her lungs were clear bilaterally. Med. recs. at Ex. 12, p. 11.

On August 8, 1994, petitioner telephoned her doctor for a refill of pain medication. She was advised that no more Percoset would be provided to her. *Id.*

On February 11, 1997, petitioner went to Carteret General Hospital, complaining of four days of constipation and low back pain. She also had headache and nausea. She stated that her

bowel movement felt like it wanted to come out of the wrong area. Coughing led to incontinence. Med. recs. at Ex. 14, p. 18.

On February 26, 1997 (the day after her alleged third hepatitis B vaccination), petitioner saw Dr. Arthur G. Klose, a urologist, for evaluation of microhematuria. Med. recs. at Ex. 9, p. 10. She saw Dr. Walter Wardell in early February (petitioner has not filed this record), complaining of back pain. Urinalysis showed 1+ blood by dipstick. Petitioner was treated with antibiotics and continued to have trace blood. She had bilateral mid back pain without nausea or vomiting. She also had recent stress urinary incontinence requiring light padding. She did not have hematuria. She had a history of urinary tract infections as a child and an adult but not notable for pyelonephritis. She was gravida 5, para 1, and had a hysterectomy in her teens for endometriosis. She smoked a pack of cigarettes a day. She took Estrace 2 mg. *Id.*

On February 28, 1997 (three days after her alleged third hepatitis B vaccination), petitioner had imaging of her pelvis done. Med. recs. at Ex. 2, p. 57. The film revealed multiple calcifications in the right aspect of the pelvis which probably represented pelvic phleboliths. One of these overlay the distal ureter on one of the views, but Dr. Thomas W. Stohrer did not feel there was obstruction. She had a negative IVP (intravenous pyelogram). *Id.*

On March 3, 1997, petitioner saw Dr. Klose for a cystoscopy which was negative. Med. recs. at Ex. 9, p. 10.

On March 17, 1997, petitioner saw Dr. Klose for stress incontinence. She had irritative voiding symptoms the last few days. Dr. Klose suspected the blood was probably vaginal and not urethral because of the normal cystoscopy. Med. recs. at Ex. 9, p. 9.

On March 24, 1997, petitioner returned to Dr. Klose for a repeat cystoscopy because of continued hematuria. The cystoscopy and urethroscopy were clear. For the past 24 hours, she had some diarrhea and passage of mucous with her bowels. Her stools were guiaic positive. Dr. Klose did not know the cause of her bleeding. Med. recs. at Ex. 9, p. 9.

On April 7, 1997, petitioner saw Dr. Wray for a colonoscopy, complaining of increasing difficulty in defecation over the prior six months (putting onset at October 1996). Med. recs. at Ex. 2, p. 55. She gave an excellent history for having a rectocele,[2] but on physical examination, she did not have a rectocele. *Id.* Petitioner complained of alternating diarrhea and constipation. She had a normal colonoscopy. Med. recs. at Ex. 2, p. 56. She had a redundant colon, particularly in the sigmoid. There was no diverticulum and Dr. Wray stated that nothing suggested a rectocele. She had moderately sized internal hemorrhoids. *Id.*

On April 10, 1997, petitioner saw Dr. Rawls because of problems with pain. Dr. Yurko suggested the possibility of endometriosis. Med. recs. at Ex. 12, p. 9.

On April 14, 1997, petitioner went to Dr. Rawls. Med. recs. at Ex. 12, p. 9. Petitioner was status post-total vaginal hysterectomy and bilateral salpingo-oophorectomy in 1994 for pelvic pain and a history of endometriosis. She had done well until about two months previously (February 1997) when she began having bowel complaints with severe constipation and pain. *Id.* She had a lifelong history of constipation which worsened in the last two months. In addition, she had broader complaints of urinary spasm and incontinence, muscle aches and pains. This seemed to be gradually worsening. There was concern about the possibility of recurrent

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[2] Rectocele is a "hernial protrusion of part of the rectum into the vagina." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1597.

endometriosis. *Id.* Petitioner's general medical health was good. *Id.* On physical examination, there was tenderness in the lower abdomen and along the vaginal cuff. Med. recs. at Ex. 2, p. 49. Her extremities were normal and she was neurologically grossly intact. *Id.*

On April 17, 1997, petitioner had a laparoscopy and Dr. Rawls reported there was no evidence whatsoever of endometriosis. Med. recs. at Ex. 2, p. 50.

On April 22, 1997, petitioner had a post-operative checkup with Dr. Rawls. She complained of vomiting since the April 17th surgery three times. She complained of a lot of nausea. Dr. Wardell gave her Phenergan. She also complained of severe bladder spasms and said she felt worse than she had a few days earlier. Med. recs. at Ex. 12, p. 10. Dr. Rawls suspected petitioner's increase in symptoms was related to the anesthesia and carbon dioxide gas in the stomach during the laparoscopy. The remainder of her symptoms remained unexplained. *Id.*

On April 28, 1997, petitioner phoned Dr. Rawls and said she felt the same. She was to have an MRI per Dr. Wardell on the next day. *Id.*

On April 30, 1997, petitioner returned to Dr. Klose because of bladder instability. Dr. Wray did a colonoscopy and Dr. Rawls did a laparoscopy and the results of both procedures were negative. Med. recs. at Ex. 9, p. 8. Dr. Wardell did an MRI to evaluate her suprapubic and flank complaints. She was taking medication for irritable bowel syndrome. The MRI did not show any kidney abnormality. Petitioner was convinced that the right kidney was the source of her discomfort. *Id.*

On May 19, 1997, petitioner saw Dr. Joseph M. Khoury, a urologist, at the University of North Carolina Hospitals. Med. recs. at Ex. 18, p. 11. He wrote a letter to Dr. Klose on May 18,

1997, stating that petitioner's neuro-urologic examination was within normal. *Id.* She had hematuria with a history of urinary tract infections as a teenager. Med. recs. at Ex. 18, p. 13. As a child, she twice had a history of pyelonephritis with urethral dilatation. She had a history of irritable bowel syndrome. *Id.* On examination, she was negative for rectocele and stress urinary incontinence. Tone, control, and perineal sensation were within normal with good Kegel exercises. Med. recs. at Ex. 18, p. 14.

On June 16, 1997, petitioner went to Carteret General Hospital complaining of pain in her left arm, left shoulder, left wrist, and left forearm whose onset was one hour previously. Med. recs. at Ex. 2, p. 46. She stated her husband beat her and she was hit in the back of the head. Petitioner complained of blurry vision and dizziness. Bruising was noted on her left wrist and abrasion was noted on her left forearm. *Id.*

On August 5, 1997, petitioner saw Dr. Clarence E. Ballenger, a neurologist, on referral from Dr. Wardell. Med. recs. at Ex. 3, p. 17. Petitioner complained of abdominal pain and a lot of diarrhea and constipation that started with a kidney infection in February 1997. *Id.* She was found to have microscopic hematuria. Her IVP and cystogram were normal. She had some heme positive stool which led to a colonoscopy which was negative. She had a history of endometriosis and a hysterectomy. She was diagnosed with bladder spasm and got a laparoscopy where she was found to have some adhesions but not endometriosis. An MRI of the pelvis and abdominal examination were normal. She saw a urologist who suggested the possibility of demyelinating disease. She had been on Ditropan for spasms and Ultram since April 30, 1997. She was on 300 mg, two of them four times a day. Dr. Wardell was concerned about addiction. She began developing what looked like a rubral tremor occurring with the bladder spasms in

June. Her right foot became inverted. Her husband beat her and there was a question of poisoning. Petitioner told Dr. Ballenger that sometimes she had difficulty talking. She had what seemed to be a rubral tremor with increased tone on the right side but intact cranial nerves. *Id.*

On August 5, 1997, petitioner had an MRI of her brain. Med. recs. at Ex. 14, p. 20. Dr. Thomas Stohrer noted she had a normal appearing brain and minimal mucosal thickening seen in her sinuses. *Id.*

On August 6, 1997, petitioner had an MRI of her total spine. Med. recs. at Ex. 14, p. 22. Dr. Elizabeth D'Angelo noted that the cerebellar tonsils protruded 5 mm below the foramen magnum without definite flattening of the medulla. The entire spinal canal had diffuse mild narrowing compatible with congenital spinal stenosis. There was moderately sized disc herniation which moderately flattened the cervical cord at the C5-6 level. There was subtle increased T2 cord signal at the level of the disc herniation, suggesting edema or gliosis of the cord. There was moderate ventral spurring at the T10-11 level of the thoracic spine. There was a small annular disruption at the L4-5 level of the lumbosacral spine. *Id.*

On August 7, 1997, petitioner returned to Dr. Ballenger. Med. recs. at Ex. 3, p. 3. The MRI of her brain was normal. He was going to proceed with a lumbar puncture to look for oligoclonal bands. Her cervical spine MRI showed a moderate disc herniation with flattening of the cervical cord at C5-6. There was some edema and gliosis of the cord based on a subtle increased T2 cord signal. There was some moderate ventral spurring at T10-11. Her lumbosacral spine MRI revealed some bulging at L4-5. Her cerebellar tonsils protruded 5 mm

below the foramen magna without obvious flattening of the medulla (Arnold-Chiari malformation)[3]. She had a history of a bleeding ulcer many years ago. *Id.*

Dr. Ballenger provided an addendum to the August 7, 1997 visit. He performed a lumbar puncture. Her heavy metals returned normal for lead and mercury. *Id.*

On August 12, 1997, petitioner saw Dr. Ballenger. Her spinal fluid was negative. Spinal fluid protein was normal. Med. recs. at Ex. 3, p. 4. The lumbar puncture on August 7, 1997 resulted in a report dated August 14, 1997 that one oligoclonal band was detected in the cerebrospinal fluid, but not in the serum. This result did not support evidence for MS, but might reflect a central nervous system inflammatory process. Med. recs. at Ex. 19, p. 22.

On August 14, 1997, petitioner went to the University of North Carolina. Med. recs. at Ex. 18, p. 3. In a letter dated August 18, 1997, Dr. James F. Howard, a neurologist and director of the neuromuscular disorders section, wrote to Dr. Joseph Khoury, a urologist, that petitioner's cervical spondylosis was contributing to her urinary difficulties. "By reports at least there is nothing to suggest a demyelinating disorder." *Id.* Her brain MRI was normal. MRI of the spine showed a small spinal canal consistent with spinal stenosis, increased cord signal at the level of T2, moderate degenerative disease changes at C5-6, and moderately severe spondylosis at T10-11. In addition, she had a 5 mm depression of her cerebellar tonsils into the cervical canal suggestive of a Chiari malformation. *Id.*

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[3] Arnold-Chiari malformation is "herniation of the cerebellar tonsils and vermis through the foramen magnum into the spinal canal. It is always associated with lumbosacral myelomeningocele, and hydrocephalus and mental defects are common." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1090.

On August 18, 1997, petitioner saw Dr. Ballenger. "[H]er oligoclonal banding showed none." She might need surgery on her neck for the Arnold-Chiari. Med. recs. at Ex. 19, p. 15.

On August 27, 1997, petitioner saw Dr. Valentine Hamilton in Morehead City, NC, for an infected right big toe, and numbness in the right fifth toe and right foot. There was spasticity of the foot with full roll of the foot and a deformed hallux (big toe). Med. recs. at Ex 23, p. 3.

On September 8, 1997, petitioner saw Dr. Ballenger. He thought she should be examined by Dr. Barrie Hurwitz at Duke to see if he agreed with Dr. Ballenger that she had MS plus cervical spondylosis. Med. recs. at Ex. 19, p. 13.

On October 6, 1997, petitioner saw Dr. Ballenger. She was developing headaches which he thought were possibly related to her cervical spondylosis. Med. recs. at Ex. 3, p. 5. He wanted her to see Dr. Barrie Hurwitz at Duke. *Id.*

On October 16, 1997, petitioner telephoned Dr. Ballenger. She was having more bladder spasms and made the appointment with Dr. Hurwitz. Dr. Ballenger thought she had MS. *Id.*

Petitioner did not file the records of her visit with Dr. Hurwitz at Duke University.

On October 27, 1997, petitioner saw Dr. Ballenger. Dr. Hurwitz did not think she had MS and did not think she needed surgery. Med. recs. at Ex. 3, p. 6. She asked for a referral to Dr. John Leonard, a neurosurgeon. *Id.*

On October 28, 1997, petitioner saw Dr. Leonard. Med. recs. at Ex. 15, p. 11. Her problem had been evolving over the past year (putting onset at October 1996). She had chronic neck discomfort with radiation of pain into the shoulders but never any radicular pain in her arm. She developed at first a constant tremor of her right arm present at rest and on intention. She then developed a progressive equinas deformity of the right foot at the ankle. She also developed

subjective weakness of her right side and also bladder spasms. She had had headaches and low back pain. Recently, she noted that with a bout of bronchitis, when she coughed suddenly, she felt pins and needles in her hands and legs. Her family physician Dr. Wardell referred her to Dr. Ballinger who thought she had demyelinating disease. She had extensive MRIs of the brain and spinal cord with no abnormality seen except for a central disc herniation at C5-6. Dr. Abraham saw her and thought she should have a myelogram and postmyelogram CT scan. She had a known allergy to iodinated compounds. Dr. Abraham did nothing further. Dr. Ballenger sent petitioner to Dr. Hurwitz at Duke. Dr. Hurwitz did not think she had demyelinating disease, but did feel she had cervical cord compression. Petitioner said that Dr. Hurwitz told her that anterior cervical diskectomy with relief of her cervical cord compression should correct all her present problems. However, Dr. Leonard read Dr. Hurwitz's notes and did not get the impression from them that Dr. Hurwitz stated surgery would solve her problems. *Id.*

On examination, petitioner had good strength in both upper extremities. However, the distal right upper extremity was difficult to examine because of a constant almost pill rolling type of tremor of the hand at rest which became worse with action. *Id.* Dr. Leonard did not find increased tone in the arm. Med. recs. at Ex. 15, p. 12. The tone in the right lower extremity was normal and even less than the left. There was a very equivocal increase of tone in the left lower extremity. She was not dysarthric or ataxic. Dr. Leonard reviewed petitioner's MRI scan showing she had a central disc protrusion, worse toward the left than toward the right at C5-6. There was compression of the cervical cord of a mild to moderate degree. *Id.* An anterior cervical diskectomy would alleviate compression from her spinal cord, but would not alleviate symptoms of her right upper extremity and right lower extremity. It might help her bladder

problem if that were due to a hypertonic neurogenic bladder. *Id.* Petitioner opted to have the surgery. Med. recs. at Ex. 15, p. 13.

On October 28, 1997, Dr. Leonard wrote an admission history and physical, noting that petitioner had a fracture of her lumbar spine in the distant past. She had also had recurrent bouts of bronchitis since she was a child. Med. recs. at Ex. 15, p. 9.

On November 12, 1997, Dr. Leonard performed an anterior cervical diskectomy at the C5-6 level on petitioner. Med. recs. at Ex. 15, p. 7. She was discharged from Pitt County Memorial Hospital on November 14, 1997. Med. recs. at Ex. 15, p. 4.

At that point, petitioner evidently saw Dr. Shuping whom, she asserted, told her that she has a rare form of epilepsy called spinal cord epilepsy[4]. Med. recs. at Ex. 15, p. 3. There is a record dated November 13, 1997 that is a neurologic consult, but the signature is impossible to read. It is written by more than one hand and could be signed by Dr. Shuping. Med. recs. at Ex. 16, p. 24. The reason for the consult was to evaluate petitioner's movement disorder. Petitioner began having bladder spasms with tremor in her right arm in April 1997. The doctor's impression was spinal seizure vs. functional vs. benign tremor vs. tremulousness of fatigue. *Id.*

On November 19, 1997, petitioner returned to Dr. Ballenger to get her staples removed. Dr. Ballinger did not do that and referred petitioner to Dr. Abraham. Petitioner told Dr. Ballenger she was diagnosed with spinal epilepsy. Med. recs. at Ex. 3, p. 6. Dr. Ballenger ordered a 24-hour EEG. Petitioner complained bitterly of constipation. He did not think it was spinal epilepsy and it did not look like myoclonus. *Id.*

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[4] According to Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 628, epilepsy concerns "paroxysmal transient disturbances of the brain function...." It does not mention spinal cord epilepsy or spinal cord seizure.

On November 27, 1997, petitioner went to Pitt County Memorial Hospital Emergency Department, complaining of right facial numbness and right temporal headache which began that day. Med. recs. at Ex. 16, p. 3. Dr. John E. Gough concluded petitioner had a headache of unclear etiology. Med. recs. at Ex. 16, p. 8. A CT scan was performed which revealed no mass lesion and no intracranial bleed. Med. recs. at Ex. 16, pp. 7, 14. There was no nausea, vomiting, fever, chills, or neck stiffness. Med. recs. at Ex. 16, p. 8.

On January 5, 1998, petitioner saw Dr. Ballenger complaining of a tremendous amount of back pain. Med. recs. at Ex. 3, p. 7. Dr. Ballenger ordered EMG and nerve conduction studies.

On January 9, 1998, petitioner had a nerve conduction study done which was essentially normal. Med. recs. at Ex. 3, p. 11.

On January 9, 1998, petitioner saw Dr. Ballenger. Her EMG and nerve conduction studies were basically normal in her lower extremities. She had still to get her 24-hour EEG. *Id.*

On January 26, 1998, petitioner saw Dr. Ballenger. Her 24-hour EEG was negative. Med. recs. at Ex. 3, p. 8.

On February 9, 1998, petitioner went to the emergency room, complaining of numbness in her vagina and rectal area, and stress incontinence. Med. recs. at Ex. 9, p. 6.

On February 11, 1998, petitioner saw Dr. J. Ross Shuping, a neurologist. Med. recs. at Ex. 6, p. 2. Her tremor seemed to get better when he distracted her. He mentioned there might be a spinal cord seizure. *Id.*

On February 20, 1998, petitioner saw Dr. Klose for a neurogenic bladder. Med. recs. at Ex. 9, p. 6. She described herself as having epilepsy of the spinal cord. She was taking multiple

muscle relaxers which helped resolve her urinary incontinence. She went to the ER and was treated for cystitis. She had mild stress incontinence but not urgency incontinence. *Id.*

On March 2, 1998, petitioner saw Dr. Ballenger. She was going to have foot surgery. She had developed a urinary tract infection. *Id.* Dr. Ballenger still thought she had MS.

On March 3, 1998, petitioner saw Dr. Jeffrey K. Moore for a preoperative history and physical. Med. recs. at Ex. 2, p. 31. Petitioner had problems with a contracture of the right foot and ankle due to a rare type of spinal cord epilepsy for the prior several months. She had a very strong contracture of the posterior tibial tendon, causing her foot to plantar flex and invert. She had a history of epilepsy, congenital spinal stenosis, and degenerative disc disease. *Id.* She complained of some bladder spasm and urinary symptoms. Med. recs. at Ex. 2, p. 32.

On perhaps March 6, 1998 (the month is eliminated in the photocopy), petitioner complained to her doctor of a loss of sensation in the vaginal area. Med. recs. at Ex. 12, p. 15.

On March 16, 1998, petitioner had a preoperation physical. Med. recs. at Ex. 2, p. 34. She had a history of MS and contracture of the right ankle. *Id.* Petitioner had a fairly pronounced tremor in the right upper extremity. Motor sensory exam was intact. The right lower extremity revealed a very tight flexible contracture of the right ankle. There was extreme inversion of the ankle and forefoot. *Id.*

On March 17, 1998, petitioner had a split anterior tibial tendon transfer in her right foot. Med. recs. at Ex. 2, p. 28. Dr. Jeffrey K. Moore diagnosed her with dynamic varus[5] spastic deformity of her right foot. Med. recs. at Ex. 2, p. 29. He records that over the last year, she had

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[5] Varus means "bent or twisted inward, denoting a deformity in which the angulation of the part is toward the midline of the body." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 2009.

an insidious, progressive neurologic condition. There were components of a peripheral neurologic problem in the cervical spinal cord area, but also a central nervous system problem, which resulted in a persistent, dynamic varus deformity of the right foot, and weakness in the right arm and hand. Med. recs. at Ex. 2, p. 28. Her neurologist considered this to be a permanent, spastic problem primarily affecting the tibialis anterior muscle. This was untreatable with bracing and casting because of the strong dynamic nature of the condition. *Id.*

On March 30, 1998, petitioner saw Dr. Ballenger, complaining of more episodes of flexor spasms, which were not seizures. She did not lose consciousness and they could occur in both legs. On examination, Dr. Ballenger did not get much spasticity. He decided to put petitioner on Baclofen in addition to her Diazepam, although it might sedate her. Dr. Ballenger did not get that much hyperreflexia in petitioner's lower extremities on examination where she would need Baclofen, but he would try it to see if it would help. Med. recs. at Ex. 19, p. 3.

On April 6, 1998, petitioner saw Dr. Ballenger. Her numbness was better and her constipation improved. Dr. Ballenger was not sure he could relate this improvement to the Baclofen. Med. recs. at Ex. 3, p. 9.

On May 8, 1998, petitioner saw Dr. Klose, complaining of aggravated stress urinary incontinence. She told Dr. Klose she had gained 100 pounds in the last year. She had more significant incontinence when she coughed or sneezed. She was using multiple muscle relaxers. Med. recs. at Ex. 9, p. 4.

On May 11, 1998, petitioner saw Dr. Ballenger. She brought in information about hepatitis B vaccine. She stated that she received her first hepatitis B vaccination on August 27, 1996, her second hepatitis B vaccination on October 7, 1996, and her third hepatitis B

vaccination on February 25, 1997. She brought information in from Dr. Bonnie Dunbar of Baylor College of Medicine whom Dr. Ballenger tried to call, but Dr. Dunbar was out of the country. Dr. Ballenger said he would research this. *Id.*

On May 22, 1998, petitioner saw Dr. Klose, complaining of a dark discharge and increasing pain in her lower left and right flanks that was worse when her bladder was full. Dr. Klose felt the discharge was not arising from either the urinary tract or the vagina. Med. recs. at Ex. 9, p. 3.

On May 28, 1998, petitioner saw Dr. Ballenger. She had fallen. *Id.* Her back had bothered her since then. Dr. Ballenger offered a second referral to Duke, but she said she was not impressed and did not want to go back there. Med. recs. at Ex. 3, p. 10. Dr. Ballenger said he would read Dr. Bonnie Dunbar's notes that petitioner gave him. *Id.*

On June 25, 1998, petitioner saw Dr. Vicki L. Wheelock, a neurologist at the University of California, Davis Medical Center, and Dr. For-Shing Lui, also a neurologist. Med. recs. at Ex. 10, p. 19. She was referred for a tremor of the right side. Petitioner told Dr. Wheelock that her symptoms probably started in September 1996 when she started to feel very tired and fatigued. She that this was due to exhaustion secondary to long hours of working as a secretary in a hospital. In February 1997, she had recurrent spells of acute lower abdominal cramps later thought to involve the urinary bladder. These were associated with tremor involving the right side and often fever. She was diagnosed with urinary infection. She had kidney ultrasounds and urodynamics done resulting in a diagnosis of neurogenic bladder. She did not have a history of hesitancy or urinary retention. After she was prescribed Ditropan and Zanaflex, her urinary symptoms completely resolved. Since April 1997, she started to have persistent tremor in

moving the right upper extremity with occasional involvement of the right lower extremity. Starting in June 1997, her right foot curled inward, causing pain in her right ankle. *Id.* She had abnormal posturing and problems walking. She fell a couple of times and required an elbow clutch to walk. MRI of the head and cervical spine showed a 5 mm Arnold-Chiari type I malformation. There was mild congenital cervical canal stenosis and significant C5-6 disk prolapse. Otherwise, the MRI of the brain was normal. MRIs of the thoracic and lumbar spine showed minimal degenerative lumbar disc disease. She had 24-hour beta EEG monitoring done which was normal. She had a lumbar puncture which was normal with no oligoclonal bands. She had heavy metal screening done with normal results. In November 1997, she had a C5-6 diskectomy done in NC. Her symptoms persisted despite the surgery. She complained sometimes of postural dizziness and her mouth and tongue always felt dry. *Id.* Her neurologist in NC told her she probably has MS. She was on Norflex, Orphenadrine, Promethazine, Ditropan, Zanaflex, Diazepam, Esterase, Darvocet, and Docusate. Med. recs. at Ex. 10, p. 20. She had multiple gynecological problems before including endometriosis, ovarian cysts, and hysterectomy. She had four Caesarean sections. Her sister suffered a pontine hemorrhage at the age of 25 believed due to some vascular malformation. Her mother and grandmother had diabetes. Her maternal uncle had Parkinson's disease. Her father and all the members of his family had coronary artery disease. *Id.*

Petitioner was an ex-smoker and abused methamphetamine in her teens. She weighed 233 pounds. She had a tendon transfer operation. She had a high frequency 6-9 hertz tremor involving the right forearm that was exaggerated by use of her right hand, writing, and also walking. *Id.* The motor tone was normal in all four extremities. Med. recs. at Ex. 10, p. 21.

Motor strength was normal, but there was impairment of fine motor movement of the right hand. Her clinical picture was not typical of MS. Petitioner should stop taking Phenergan. *Id.*

On June 25, 1998. Dr. Wheelock wrote a letter to Dr. Dean Stoller. Med. recs. at Ex. 10, p. 16. She notes that petitioner used methamphetamines daily for several years while she was a teenager. *Id.* Petitioner's MRI of her brain in August 1997 was quite normal. Med. recs. at Ex. 10, p. 17. Dr. Wheelock's impression was that petitioner had a most unusual extrapyramidal syndrome with resting tremor and bradykinesia of the right arm and dystonic posturing of the right leg with no readily identified etiology. *Id.* Dr. Wheelock recommended petitioner stop taking Phenergan since its dopamine blackade was probably going to aggravate her right-sided motor symptoms. Med. recs. at Ex. 10, p. 18.

On August 1, 1998, petitioner had an MRI of her brain which showed no intracranial abnormality. There was some mild left ethmoid and maxillary sinus mucosal thickening. Med. recs. at Ex. 17, p. 89.

On August 31, 1998, petitioner saw Dr. Wheelock. Med. recs. at Ex. 17, p. 59. She had normal tone in the right upper extremity. Plantar reflexes were downgoing. Petitioner reported to Dr. Wheelock that she had investigated a possible link between hepatitis B vaccine and the onset of her symptoms. She provided Dr. Wheelock with some references. Petitioner was in touch with Dr. Bonnie Dunbar at Baylor College of Medicine. Dr. Wheelock left a message for Dr. Dunbar to call her back. Petitioner had a slightly elevated ANA and fibroid peroxidase autoantibody. *Id.* Her rheumatoid factor was negative and all other antibodies on the lupus panel were negative. Med. recs. at Ex. 17, p. 60. Petitioner's MRI brain scan of August 1, 1998 was completely normal, showing no evidence of demyelination or of signal change within the basal

ganglia. *Id.* Dr. Wheelock's impression was that petitioner had an extrapyramidal[6] syndrome, characterized primarily by right hand tremor and right lower extremity dystonia of unknown etiology. She had no evidence of demyelinating disease on two MRI scans and negative spinal fluid examination in the past which made demyelinating disease unlikely. *Id.* Petitioner was taking Demerol with Phenergan, Compazine, and Promethazine over the last year and one-half. These medications can produce extrapyramidal side effects and it appears that petitioner took at least some of them prior to developing her right foot dystonia. Dr. Wheelock recommended that petitioner refrain from all use of neuroleptic drugs and all antiemetics that block dopamine. She asked her to try Trazodone 50-150 mg at bed time to treat her right hand tremor. She might benefit from anticholinergic drugs. *Id.*

On September 4, 1998, petitioner had a cervical spine x-ray after a fall and complained of neck and head pain. It showed disc space narrowing at C5-6 consistent with degenerative joint disease changes. Med. recs. at Ex. 17, p. 87.

On September 4, 1998, petitioner had a hip and pelvis x-ray for the same reason, which was normal. Med. recs. at Ex. 17, p. 88.

On September 4, 1998, petitioner went to the University of California, Davis Health System, Emergency Department, because she tripped and fell on a cup the prior evening. Med. recs. at Ex. 20, p. 20. Petitioner complained of pain in her neck, right arm, right leg with

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[6] Extrapyramidal system is "an imprecise term referring to a functional rather than an anatomical part of the central nervous system that controls motor activities and is not part of the pyramidal tract; it includes the corpus striatum, subthalamic nucleus, substantia nigra, and red nucleus along with their interconnections with the reticular formation, cerebrum, and cerebellum; they control and coordinate especially the postural, static, supporting, and locomotor mechanisms." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1842.

numbness and pins and needles. She did not lose consciousness. She had ongoing abdominal pain. *Id.*

On September 7, 1998, petitioner went to the University of California, Davis Medical Center, complaining of urinary retention and an increase in bladder spasms. Med. recs. at Ex. 20, p. 4. She had been seen there after a fall at home. All x-rays were negative. *Id.* On examination, her toes were downgoing and her deep tendon reflexes were 2+ throughout. She was diagnosed with early pyelonephritis. Med. recs. at Ex. 20, p. 5.

On September 9, 1998, petitioner saw Dr. Viviane Ugalde and Dr. Stacy Shoemaker for evaluation for possible Botox injection. Petitioner had severe fatigue, lower abdominal cramps, and neurogenic bladder discovered approximately one year previously. Med. recs. at Ex. 20, p. 35. In April 1997, she began to experience tremor in her right upper extremity and, to a lesser extent, in her right lower extremity. In June 1997, she developed dystonic posturing of her right foot. *Id.*

On September 10, 1998, petitioner saw Dr. Wheelock. Med. recs. at Ex. 17, p. 57. Dr. Wheelock stated that petitioner "has a complex and mystifying neurologic syndrome which [petitioner] believes may be related to hepatitis B vaccination." *Id.*

On September 15, 1998, petitioner saw Dr. Sandra J. Martin, a podiatrist, for ingrown toenails. Med. recs at Ex. 10, p. 13.

On September 17, 1998, petitioner saw Dr. Donna M. Cirasole, a gynecologist, for her annual check-up and PAP test. Med. recs. at Ex. 10, p. 4. She complained of decreased sensation in the vaginal area for the last 15 months (putting onset at June 1997). Petitioner had a total of 12 laparoscopies. *Id.* Petitioner had some recent weight changes, frequent headaches,

and "a history of seizures." Med. recs. at Ex. 10, p. 5. She had difficulty walking two blocks, shortness of breath, heartburn, bleeding with bowel movements and black stools, recent change in bowel habits, urinary frequency, frequent urinary tract infections, hematuria, and leaking urine. *Id.* Petitioner's height was 5'7" and she weighed 210 pounds. *Id.* Dr. Cirasole's impression was that petitioner had yeast vaginitis. Med. recs. at Ex. 10, p. 6.

On September 29, 1998, petitioner had a renal ultrasound which showed no evidence of hydronephrosis or renal mass. Med. recs. at Ex. 17, p. 86.

On October 6, 1998, petitioner saw Dr. Mark A. Agius, a neurologist, at the University of California, Davis Medical Center. Med. recs. at Ex. 17, p. 28. She had a one year and eight-month history of stress incontinence, kidney infection, bladder spasms with pain, right-sided shaking, right hemiparesis with right foot turning in with weakness. She had an operation to lengthen the tendon in March 1998. Petitioner had a history of two miscarriages and an ectopic pregnancy. She had numbness of her right little toe, and tingling of her right leg and right arm. The course was slow and progressive. Onset was fairly acute over a few days with recurrent attacks. *Id.* She had a function tremor at rest in her right hand and arm. Her right foot was dystonic and inverted. Dr. Agius' diagnosis was weakness, involuntary movements, apparently dating to a hepatitis B immunization series, with symptoms starting between the second and third vaccinations and symptoms worsening after the third vaccination; history of cervical spinal stenosis, moderate central disc herniation at C5-6 with moderate flattening of the cervical cord; mild disc T10-11; Arnold-Chiari malformation, mild diffuse narrowing of the entire spinal canal consistent with congenital spinal stenosis; right equinovarus contracture; low back pain with paravertebral muscle spasm; neurogenic bladder on Ditropan; and single oligoclonal band on

cerebrospinal fluid. Med. recs. at Ex. 17, pp. 29-30. The presence of high levels of IgG and IgM anticardiolipin antibodies suggested a possible connective tissue disorder. Phospholipid antibodies in the presence of a history of miscarriages suggested phospholipid syndrome.[7] Med. recs. at Ex. 17, p. 30.

On October 8, 1998, petitioner returned to see. Dr. Wheelock. Med. recs. at Ex. 17, p. 55. Petitioner's recent laboratory workup found that she had a positive anticardiolipin antibody with a titer of 40.4 for the IgM fraction consistent with antiphospholipid antibody syndrome. Dr. Wheelock's impression was that petitioner may have central nervous system manifestations of possible lupus. *Id.*

On October 29, 1998, petitioner had an EEG to rule out seizures. Med. recs. at Ex. 17, p. 85. Her EEG was normal. *Id.*

On November 20, 1998, petitioner had a posterior tibial somatosensory evoked potential study to rule out MS. Med. recs. at Ex. 17, p. 81. The tibial somatosensory evoked potential study was normal on both sides without evidence for a conduction delay in the sensory pathway in the left and right lower extremities. *Id.*

On November 20, 1998, petitioner had a median nerve somatosensory evoked potential study to rule out any abnormality of the sensory pathways. Med. recs. at Ex. 17, p. 82. The median nerve somatosensory evoked potential study of her upper extremities was normal without

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[7] Antiphospholipid syndrome is "a multisystem inflammatory disorder characterized by the presence of circulating antiphospholipid antibodies and by thrombosis and vascular occlusion, spontaneous abortion, thrombocytopenia, valvular heart disease, and other less frequent symptoms." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1810.

any evidence of conduction abnormality along the peripheral nerves stimulated, dorsal columns, median lemniscus or thalamacortical pathways. *Id.*

On November 20, 1998, petitioner had a brainstem auditory evoked potential study to rule out any abnormality in the auditory pathways. Med. recs. at Ex. 17, p. 83. She had a normal brainstem auditory evoked potential study with no evidence of conduction abnormality along the auditory pathways bilaterally. *Id.*

On November 20, 1998, petitioner had visual evoked potentials recorded for both eyes and the result was normal. Med. recs. at Ex. 17, p. 84.

On November 23, 1998, petitioner saw Dr. Esther Kim, an ophthalmologist, complaining of visual loss. Her stereo acuity was pretty good. Med. recs. at Ex. 17, p. 92.

On November 24, 1998, petitioner was given a phenol nerve block of her right tibial nerve because of focal dystonia secondary to an extrapyramidal syndrome from vasculitis. Med. recs. at Ex. 20, p. 53. Signing the report were Dr. Ugalde and Dr. Shoemaker. *Id.*

On February 10, 1999, petitioner went to the Emergency Department of Loma Linda University Medical Center, complaining of back pain. Med. recs. at Ex. 5, p. 36. Dr. Mark G. Richmond and Dr. Jai H. Ho took a history that petitioner had a history of autoimmune disease. On examination, her motor strength was 5 out of 5 in her upper and lower extremities with some weakness in the right leg. Deep tendon reflexes were symmetric. Straight leg raise was negative bilaterally. Their impression was lumbar strain and upper respiratory tract infection. *Id.*

On February 24, 1999, petitioner went to Loma Linda University Medical Center, complaining of back pain. Med. recs. at Ex. 5, p. 29. Spousal abuse began in June 1997 with financial problems. Med. recs. at Ex. 5, p. 30. The husband physically beat petitioner and then

threatened to kill her. Her back pain worsened since she had the flu in February 1999. *Id.* Petitioner had an increase in coughing that caused sharp right upper back pain radiating to her behind and right leg. *Id.*

On February 26, 1999, petitioner went to Loma Linda University Medical Center. Med. recs. at Ex. 5, p. 17. She had degenerative disc disease, Arnold-Chiari syndrome, congenital spinal stenosis, bladder incontinence, "mini strokes," questionable thyroid function abnormalities, questionable autoimmune reaction to hepatitis B vaccine, ruptured vertebrae and diskectomy, severe back pain, right foot contracture, and physical spousal abuse (her husband broke her neck in 1997). She was previously healthy until February 1997 when she developed multiple symptoms: right upper extremity tremor, bladder spasms, right foot inversion, and febrile episodes after her second hepatitis B vaccination (petitioner alleges her second hepatitis B vaccination was October 1996, not February 1997). Neurologists in NC initially felt she had either MS or spinal cord epilepsy. *Id.* Twenty-four-hour EEG did not show abnormalities. Med. recs. at Ex. 5, pp. 17-18. Dr. D. Lambert concluded that petitioner had multiple medical problems with some questionable functional overlay. Med. recs. at Ex. 5, p. 22. She had right upper extremity tremor with foot dystonia, not typical for Parkinson's and no other features. It was not rhythmic. She had a history of Compazine use prior to onset. There was a questionable functional component. *Id.*

On March 16, 1999, petitioner went to Loma Linda University Medical Center. Dr. C. Batt wrote that she had a history of degenerative disk disease, Arnold-Chiari malformation, spinal stenosis, bladder incontinence, and stroke. Med. recs. at Ex. 5, p. 16. An orthopedist saw

her in Davis, CA, for an articulating AFO secondary to equinus deformity or pronator contracture. *Id.*

On April 6, 1999, petitioner went to San Bernardino County Medical Center Emergency Room because of an assault. Med. recs. at Ex. 25, p. 45. Her boyfriend assaulted her with a wooden kitchen chair. She complained of left body pain. Med. recs. at Ex. 25, p. 45. The police report number was 994353. Med. recs. at Ex. 25, p. 47. (Petitioner did not file the police report.)

On April 6, 1999, petitioner had a CT scan done of her spine because of the assault. The findings were straightening of the cervical curvature and moderately advanced degenerative disc changes seen at the C5-6 level. There was a question of separation of the intervertebral body of C7-T1 as noted by widening of the intervertebral disc space. Med. recs. at Ex. 25, p. 19.

On April 6, 1999, petitioner had a CT scan done of her complete spine because of the assault. She had degenerative changes in the mid and lower cervical spine with a question of ligamentous injury at C7-T1 suggested by widening of the intervertebral disc space at that juncture. Med. recs. at Ex. 25, p. 21.

On April 6, 1999, petitioner had a CT scan done of her cervical spine due to widening of the disc space at C7-T1. Med. recs. at Ex. 25, p. 16. There was severe degenerative change with extensive marginal osteophyte, causing neural foraminal and spinal stenosis without acute fracture from C5 through T1. *Id.*

On April 6, 1999, petitioner had a CT scan done of her abdomen due to trauma. There was no injury to the liver, spleen, kidneys or pancreas. There was increased density in the gallbladder of undetermined significance. This was an essentially normal noncontrast study of the abdomen. Med. recs. at Ex. 25, p. 17.

On April 6, 1999, petitioner had a CT scan done of her pelvis due to the assault. No pelvic abnormalities were identified. Med. recs. at Ex. 25, p. 23.

On April 6, 1999, petitioner had a CT scan done of her lumbar spine due to the assault. The findings were normal lumbar curvature with minor degenerative changes in the lower lumbar region. There was no definite fracture. Med. recs. at Ex. 25, p. 20.

On April 6, 1999, petitioner had a CT scan done of her left knee because of pain. The study was negative. Med. recs. at Ex. 25, p. 22.

On April 6, 1999, petitioner had a CT scan done of her thoracic spine because of the assault. The findings were normal. Med. recs. at Ex. 25, p. 24.

On April 6, 1999, petitioner had a CT scan done of her chest because of the assault. There was no significant abnormality. Med. recs. at Ex. 25, p. 25.

On April 6, 1999, petitioner had a CT scan done of her head because of trauma. The result was no hemorrhage. She had mild thickening of the right maxillary sinus and ethmoid sinuses consistent with sinusitis. Med. recs. at Ex. 25, p. 26.

On April 6, 1999, petitioner was transported to Arrowhead Regional Medical Center by ambulance. The man who beat her up was her estranged husband. Med. recs. at Ex. 25, p. 52. Petitioner lost consciousness for about three hours after the assault (in earlier histories, petitioner told the ambulance and hospital personnel that she did not know if she lost consciousness). Med. recs. at Ex. 25, pp. 45 (unknown loss of consciousness), 50 (possible loss of consciousness), 58 (three hours' loss of consciousness). Petitioner was discharged home on April 7, 1999. Med. recs. at Ex. 25, p. 57.

On April 15, 1999, petitioner had an MRI done of her cervical spine at Loma Linda University Medical Center. Med. recs. at Ex. 5, p. 11. She had moderate degenerative disk disease at C5-6 with a small broad-based posterior diskal spur mildly narrowing the thecal sac to 9 mm with loss of the cerebrospinal fluid collar around the spinal cord. Med. recs. at Ex. 5, p. 12.

On May 6, 1999, petitioner saw a neurologist at Loma Linda University Medical Center who noted that petitioner had multiple complaints with little objective findings. Med. recs. at Ex. 5, p. 4. She stated that all her problems started after she received hepatitis B vaccine. She now had right-handed tremor and a possibly dystonic right foot. There was a class action suit against Smith/Kline. Petitioner told the doctor she had been told she had an autoimmune reaction to the hepatitis B vaccine in the form of "mini strokes" although review of her head MRI showed she was normal. She stated her thyroid panel and lupus panel were abnormal. On physical examination, she had mild ptosis in her right eye that came and went. She had giveaway pseudo-weakness on the right upper extremity. She had random alternating movements on the right but this appeared volitional. Her tone was normal. *Id.*

Petitioner's sensory examination was very inconsistent. Med. recs. at Ex. 5, p. 5. The assessment was: (1) multiple subjective complaints with little objective findings; (2) chronic low back pain on three pain medications; (3) pseudo-neurologic findings; (4) probable foot dystonia and right upper extremity tremor of unknown etiology; and (5) neck pain supposedly post-neck surgery. *Id.*

On May 24, 1999, petitioner saw Dr. H. Roger Hadley, Lima Linda Urology Medical Group, complaining of incontinence. Med. recs. at Ex. 8, p. 5. She had progressive problems

relating to her spine including spinal stenosis. She related her problems to hepatitis B vaccine. She smoked one pack of cigarettes daily. She had urethral dilations as a small child. *Id.*

Petitioner filed part of a medical record from Dr. Ballenger dated January 3, 2003, which refers to Botox. To him, petitioner looked better but she did not think so. Med. recs. at Ex. 19, p. 1.

On January 30, 2003, petitioner returned to Dr. Ballenger. He injected botulism toxin after doing an EMG and finding the psoas muscle in almost persistent contraction. *Id.*

DISCUSSION

This is a causation in fact case. To satisfy her burden of proving causation in fact, petitioner must offer "(1) a medical theory causally connecting the vaccination and the injury; (2) a logical sequence of cause and effect showing that the vaccination was the reason for the injury; and (3) a showing of a proximate temporal relationship between vaccination and injury." Althen v. Secretary of HHS, 418 F. 3d 1274, 1278 (Fed. Cir. 2005). In Althen, the Federal Circuit quoted its opinion in Grant v. Secretary of HHS, 956 F.2d 1144, 1148 (Fed. Cir. 1992):

> A persuasive medical theory is demonstrated by "proof of a logical sequence of cause and effect showing that the vaccination was the reason for the injury[,]" the logical sequence being supported by "reputable medical or scientific explanation[,]" *i.e.*, "evidence in the form of scientific studies or expert medical testimony[.]"

In Capizzano v. Secretary of HHS, 440 F.3d 1274, 1325 (Fed. Cir. 2006), the Federal Circuit said "we conclude that requiring either epidemiologic studies, rechallenge, the presence of pathological markers or genetic disposition, or general acceptance in the scientific or medical communities to establish a logical sequence of cause and effect is contrary to what we said in Althen...."

Without more, "evidence showing an absence of other causes does not meet petitioners' affirmative duty to show actual or legal causation." Grant, supra, at 1149. Mere temporal association is not sufficient to prove causation in fact. Hasler v. US, 718 F.2d 202, 205 (6th Cir. 1983), cert. denied, 469 U.S. 817 (1984).

Petitioner must show not only that but for the vaccine, she would not have had whatever she has, but also that the vaccine was a substantial factor in bringing about whatever she has. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

Dr. Ballenger's opinion that petitioner has MS is a voice crying in the wilderness. All of petitioner's other neurologists have opined that she does not have a demyelinating illness. In fact, most of her symptoms appear to be subjective, not objective. She does have antiphospholipid syndrome, which explains her prior miscarriages and may be related to possible lupus. She has selectively omitted the records of Dr. Hurwitz at Duke, and Dr. Wardwell, her primary physician. Presumably, these records contain information petitioner does not wish filed.

Petitioner gave an excellent history (the doctor's words) of rectocele to Dr. Wray on April 7, 1997, but she did not have a rectocele. She told Dr. Leonard on October 28, 1997 that Dr. Hurwitz stated that a diskectomy would solve all her problems, but Dr. Leonard read Dr. Hurwitz's notes (he had the advantage the undersigned does not have) and Dr. Hurwitz did not say this. In fact, on October 27, 1997, Dr. Ballenger noted in his own records that Dr. Hurwitz did not think petitioner had MS and did not recommend surgery. Petitioner had the surgery anyway.

Her MRIs, EEGs (including a 24-hour EEG), EMGs, and nerve conduction studies were normal except for her spinal difficulties which are structural (disc compression and spinal

stenosis). She has Arnold-Chiari malformation which may cause some symptoms. Dr. Wheelock identified that petitioner took medication that would cause extrapyramidal symptoms such as tremor and dystonia in her foot. Although petitioner told numerous doctors that Dr. Shuping had diagnosed her with spinal epilepsy, the record of November 13, 1999, if that is Dr. Shuping's signature, states that she might have any of four diagnoses: spinal seizure vs. functional vs. benign tremor vs. tremulousness of fatigue. "Functional" means not an objective illness.

It was May 11, 1998, 14 months after her alleged third hepatitis B vaccination, that petitioner, for the first time, mentioned to any doctor that she had received hepatitis B vaccine and that her symptoms began in association with the vaccine. Sometimes, she gave histories that all her symptoms began after the third vaccination in February 1997. Other times, she gave histories that all her symptoms began between the second and third vaccinations, but worsened after the third vaccination.

She saw many doctors in the 14 months after her alleged February 1997 vaccination. One would have thought that if she had post-vaccinal symptoms, she would have mentioned them before the passage of 14 months. Once she started mentioning the hepatitis B vaccine and symptoms beginning after vaccination, she brought in information about hepatitis B vaccine and showed it to Dr. Ballenger and later to Dr. Wheelock. She also brought information to them from Bonnie Dunbar, Ph.D. of Baylor College of Medicine whom both doctors tried to call. Bonnie Dunbar's brother is a petitioner in the Vaccine Program.

Dr. D. Lambert at Loma Linda Medical Center on February 26, 1999 questioned whether there was a functional overlay to petitioner's complaints, i.e., she made subjective complaints not

based on real medical conditions. On May 6, 1999, petitioner saw a neurologist at Loma Linda who also diagnosed her with multiple subjective complaints with little objective findings and pseudo-neurologic findings.

No one except Dr. Ballenger opined that petitioner had MS. Dr. Barrie Hurwitz, a neurologist at Duke, stated that she did not have MS. Dr. Wheelock, another neurologist, stated petitioner does not have a demyelinating disease. Petitioner's test results are uniformly normal for nerve conduction and the absence of lesions in her spine and brain. Petitioner does not have a demyelinating illness. Therefore, the results of the Omnibus hepatitis B vaccine-demyelinating illnesses proceeding do not apply to her.

In the eight years since petitioner filed her petition, she has not filed one expert report in support of her claims. The difficulties the undersigned outlined for petitioner six months ago have indeed proved insurmountable. The petition must be dismissed for failure to prosecute.

CONCLUSION

This petition must be dismissed. In the absence of a motion for review filed pursuant to RCFC Appendix B, the clerk of the court is directed to enter judgment in accordance herewith.[8]

IT IS SO ORDERED.

May 30, 2007
DATE

s/ Laura D. Millman
Laura D. Millman
Special Master

[8] Pursuant to Vaccine Rule 11(a), entry of judgment can be expedited by each party's filing a notice renouncing the right to seek review.